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Follow-up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS

Implementing the Declaration of Commitment on HIV/AIDS: building partnerships and expanding national responses to HIV/AIDS

I. Introduction

1. The Declaration of Commitment adopted by the General Assembly at its twenty-sixth special session on HIV/AIDS, in June 2001, contains multiple time-bound targets, the first of which fall due in 2003. To mark the occasion, the Assembly has made provision for a day of high-level plenary meetings and an informal interactive panel discussion in parallel to the afternoon session, to assess overall progress in implementing the Declaration (resolutions 57/299 and 57/308). The panel discussion, entitled "Implementation of the Declaration of Commitment on HIV/AIDS: building partnerships and expanding national responses to HIV/AIDS" will feature leaders from national Governments, the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) community, faith-based organizations and the business sector. The discussions will focus on three particular areas: addressing stigma and discrimination; building partnerships; and mobilizing financial resources.

2. While many examples of successful partnerships exist, it was clear that most countries identified this issue as one of the main factors in implementation of the Declaration. As a consequence, the Joint United Nations Programme on HIV/AIDS (UNAIDS) held a series of consultations on this issue, in conjunction with the following regional meetings:

(a) Commonwealth of Independent States Coordinating Council on HIV/AIDS, held in Yerevan in March 2003;

(b) Second Forum on HIV/AIDS and Sexually Transmitted Infections in Latin America and the Caribbean, held in Havana in April 2003;

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(c) Second meeting of the Committee on Human Development and Civil Society of the Economic Commission for Africa, held in Addis Ababa in May 2003.

3. These consultations focused on ways to achieve (a) the engagement of important partners in national responses to HIV/AIDS; and (b) the expansion of national responses to non-traditional sectors (such as the uniformed services). Participants included representatives of Governments and civil society, including organizations representing people living with HIV/AIDS, the business sector and the faith-based community. Despite efforts, representatives of the agricultural sector were not present at any of the meetings and issues pertaining to rural development and food security aspects of the response to HIV/AIDS were therefore not discussed. The uncertainty created by the severe acute respiratory syndrome (SARS) epidemic prevented the holding of a similar meeting in the Asia-Pacific region.

4. Out of this consultative process has emerged a mixed picture of progress in some areas of partnership building and continuing challenges in others. The key issues are summarized below.

II. Government leadership

5. Given the complexity and widespread impact of the HIV/AIDS epidemic, participants were united in the view that this was more than just a health issue and that Governments acting alone were not likely to be capable of mounting the response needed to reverse the epidemic. Governments nevertheless bore responsibility for leading national responses to HIV/AIDS, since they defined national priorities and controlled resources. Such leadership had to start at the top. It was only through clear pronouncements and actions at the highest political level that effective mobilization could take place.

6. Governments in all three regions reported the establishment of national multisectoral bodies, often with provincial or local authority equivalents, to coordinate activities on HIV/AIDS. In several African countries, national AIDS councils were linked to complementary coordination mechanisms such as special cabinet committees and tripartite councils comprising government representatives, employers and workers. An example was cited of local governments being empowered by the requirement that donor resources be channelled through district administrations instead of the national ministries. Aware that infection rates were high along cross-border migrant labour and transportation routes and among refugee populations, participants argued for a stronger role for existing subregional economic and security organizations.

7. The adoption of the programme of urgent measures of the member countries of the Commonwealth of Independent States to respond to HIV/AIDS has spurred actions at both the national and regional levels. National responses have been strengthened by the appointment of senior coordinators with authority spanning multiple sectors. Regional activities to combat trafficking in persons and the smuggling of illicit drugs are being coordinated through councils at the technical and ministerial levels. In many instances, however, coordination within Governments was reported as needing improvement. For example, poor coordination between drug regulatory and customs authorities often delayed the availability of imported essential medicines, while the levying of import duties and other taxes on

essential medicines added to their costs and contributed to placing them beyond the reach of those who needed them.

8. While many Governments in Latin America and the Caribbean were generally considered to be well mobilized and coordinated, in some instances national responses were said to be hampered by the change in priorities brought on by recent political and economic uncertainties. In addition, examples cited at the meeting suggested that the continuity of policies relating to HIV/AIDS was not always preserved during changes in political administration.

Expanding the national response through partnerships

Civil society

9. While the critical role played by civil society in the fight against HIV/AIDS was well recognized at each of the meetings, participants were keenly aware of the need to strengthen existing partnerships with Governments and to reach out to additional partners such as faith-based organizations and the business sector. The consultations revealed, however, that the roles and capacity of non-governmental organizations (NGOs) varied significantly from region to region and sector to sector.

10. In the Commonwealth of Independent States, NGOs noted that their particular advantage was their unique access to vulnerable populations such as men who have sex with men, intravenous drug users and commercial sex workers, whose activities constituted criminal offences under various national laws. Such access has enabled NGOs to provide direct services to those groups, often under government contracts. While such contractual relationships appeared to be working reasonably well, both parties recognized that this fell short of true partnership. They nevertheless considered it a starting point from which fuller partnerships could evolve.

11. However, each party had a different perspective on what needed to be fixed in the current relationship. Government representatives for example, lamented the fact that civil society groups were very slow to emerge, often placing Governments in the odd position of having to initiate their formation. Civil society representatives on the other hand indicated that the absence of clear legal (and by implication political) frameworks under which they could operate, hampered their ability to operate. In addition, many NGOs remained focused on the interests of their particular constituents, such as men who have sex with men and intravenous drug users, and this failure to build broader coalitions has meant that the benefits that could accrue through collective action have gone unrealized.

12. Civil society in Latin America and the Caribbean has a much longer history and a fairly well established tradition. NGO representatives at the Second Forum on HIV/AIDS and Sexually Transmitted Infections in Latin America and the Caribbean held at Havana, described a very different role for themselves; primarily as activists and advocates with Governments for stronger human rights protections and increased funding of HIV/AIDS programmes, especially those aimed at improving access to treatment. They described the targets set at the twenty-sixth special session of the General Assembly as "a floor not a ceiling" for measuring government actions. The assertion was made that some Governments paid lip service to civil society involvement, but in reality refused to accept them as full partners. The Declaration of Commitment was nevertheless seen as a useful foundation for

dialogue with Governments. In some countries, civil society organizations had acquired significant technical and organizational capacity and were professionalizing their operations for greater efficiency. Civil society efforts were, however, hampered by the region's recent political and economic crises, which interrupted access to vital medications in some countries. Many complained that the terrorist attacks of 11 September 2001 had resulted in the redirection of resources towards defence and security.

13. In Africa, the region hit hardest by the pandemic, NGO representatives were encouraged by the fact that more Governments now recognized the importance of civil society involvement and had opened greater political space for partnerships. The operating environment for NGOs however remained difficult. Extreme poverty, low educational levels, gender discrimination, poor health infrastructure and conflict continued to be major challenges and these were compounded by inadequate and unreliable funding, and low capacity.

14. There were however several unifying threads emerging from these meetings which pointed to possible solutions:

(a) Involvement of civil society at every point, from the formulation of policy through to the design and implementation of HIV/AIDS programmes and the monitoring and evaluation thereof. This would of necessity require the generation of an environment that was conducive to the full participation of civil society in all aspects of national HIV/AIDS programmes. Special efforts should be made to include women and youth;

(b) Establishing clear lines of authority, responsibility and accountability with all partners;

(c) Openness of all stakeholders to constructive criticism, recognizing that a certain degree of tension between Government and civil society is inherent in the relationship and healthy if managed properly;

(d) Increased funding for HIV/AIDS programmes from both domestic and donor sources and greater transparency in the disbursement of such resources by all partners. Equally important, these resources need to reach communities, which in reality represent the frontline in this battle.

III. People living with HIV/AIDS

15. People living with HIV/AIDS were reaffirmed as an important resource in the struggle against HIV/AIDS. Their visible presence placed a human face on the epidemic and helped challenge the stereotypes and assumptions fuelling stigma and discrimination, and they were often at the forefront of national advocacy efforts and had largely been responsible for placing the issue of care and treatment on the global agenda.

16. Obstacles to the full participation of people living with HIV/AIDS remain formidable. Stigma and discrimination were common and often reinforced by cultural and religious values. Specific protections for the human rights of HIV-positive people were either absent or poorly enforced. In many cases, they were either unaware of their rights or unwilling to assert them in the face of stigmatization. Their organization into a coherent and effective force for change was

therefore identified as a high priority in all three regions, but particularly in the Commonwealth of Independent States and in Latin America and the Caribbean, where infection rates are highest among groups already at the margins of society.

17. Various steps were suggested to enable the full participation of people living with HIV/AIDS. These included:

(a) More aggressive efforts to combat stigma and discrimination, including reform of relevant legislative and regulatory frameworks and rigorous enforcement of human rights protections;

(b) Greater action by opinion makers, such as religious and political figures, sports and entertainment personalities and private sector leaders, through inter alia, speaking out against stigma, declaring their own sero status and including people living with HIV/AIDS in their public appearances;

(c) Outreach to people living with HIV/AIDS to educate them about their rights and available services and to involve them more explicitly as leaders in HIV/AIDS programmes;

(d) Rapid scaling up of treatment, care and support programmes, including access to antiretroviral drugs. In the absence of such programmes, many people living with HIV/AIDS will continue to believe that the personal risks of stepping forward outweigh the likely benefits.

IV. Faith-based community

18. The importance of faith-based organizations in the response to HIV/AIDS was well recognized, given their long history of service in communities, their moral authority and financial and organizational resources that they command. In addition, these organizations boast a reach that cannot be matched and are often present in even the most remote areas. Representatives of faith-based organizations were frank in admitting that they had, in general, been slow to react to the epidemic, usually because of the stigma and moral overtones associated with being HIV-positive. However, as more believers fall victim to the disease, the position of many religious leaders has evolved.

19. Today most faiths have taken up the challenge of HIV/AIDS, providing spiritual comfort and support to people living with HIV/AIDS and their families, challenging stigma and discrimination and incorporating education and prevention messages into worship services. Dialogue with international religious partners and ecumenical agencies such as the World Council of Churches was credited with having played an important role in encouraging change.

20. It was noted however that faith-based programmes operate within the framework of religious values that emphasized abstinence, fidelity and compassion towards the ill. For religious leaders present at these meetings, this has meant that certain prevention methods, including condom use outside of marriage or needle exchange programmes, could not be supported. In some regions, faith-based organizations are important providers of health services and this includes the treatment of individuals with AIDS. Few are currently able to offer treatment with antiretroviral drugs, a situation that is only likely to be corrected through the provision of considerable and sustained external assistance. In other regions, faith-

based organizations considered health service provision to be beyond their limited resources and capacity and therefore something best left to others.

21. A Caribbean person living with HIV/AIDS spoke poignantly of his experience of having been rejected by his church and of the stigmatization in wider society that followed thereafter. Although some national religious leaders were challenging this type of attitude, it was not yet clear whether this had led to changed attitudes at the community level. Speakers at the Havana meeting noted that the churches provided excellent care and services for the region's AIDS orphans, although concerns were expressed about the placement of children in orphanages instead of within their extended families and communities.

22. Among the suggestions made to enhance the effectiveness of the faith-based response were:

(a) Wider dialogue with people living with HIV/AIDS, Governments and other stakeholders to form effective partnerships;

(b) Greater participation in education and prevention campaigns, especially those aimed at addressing stigma and discrimination;

(c) Expanded engagement with international denominational and ecumenical partners to enhance understanding of the epidemic and strengthen local responses;

(d) Expansion of care and treatment programmes where feasible.

V. The business sector

23. While the engagement of the business sector varied considerably across the three regions, there were nevertheless encouraging signs of the business sector becoming involved in national responses to HIV/AIDS. The activities described ranged from workplace education and prevention programmes to charitable contributions and care and treatment programmes delivered through company health schemes. In Africa and other resource-poor regions, it was noted that some large national and multinational companies had begun to provide antiretroviral medications to their workers.

24. The Brazilian business experience, as profiled at the Second Forum on HIV/AIDS and Sexually Transmitted Infections had clearly benefited from close integration with the national AIDS programme. In particular, the guarantee by the Government of access to treatment had removed a thorny issue from the table. This had helped to create an environment within which business and labour could focus on the wider issues such as worker education and prevention initiatives, as well as personnel and employment policies. While the establishment of a national business council comprising the largest companies was applauded, it was noted that their policies and practices had yet to permeate to smaller businesses where stigma and discrimination remained rife.

25. The Mozambican example, presented at the second meeting of the Committee on Human Development and Civil Society, held at Addis Ababa, which concerned the experiences of a construction company, provided the perspective of a small business owner and confirmed the vulnerability of a mobile workforce. The prevalence of HIV among field-based workers was reported to be twice that of workers at company headquarters. Awareness of HIV/AIDS was reported to be high

among small business owners, especially since the disease threatened their skilled labour force, which often represented their main asset. While acknowledging that the level of support from the national AIDS programme has meant that workplace prevention programmes could be instituted even by small businesses, delivering more comprehensive workplace programmes was an entirely different proposition. In the absence of widely accessible treatment programmes, small businesses could consider providing treatment, in particular with antiretroviral medications, only on a highly individualized case-by-case basis. Governments could encourage greater small business involvement through tax incentive programmes, by facilitating access for small business to external resources represented by donors and NGOs and by increasing access to treatment through the public health system.

26. The business sector was not represented at the meeting of the Commonwealth of Independent States Coordinating Council on HIV/AIDS, held at Yerevan, and this aspect was not formally discussed at the meeting. It was however apparent from private discussions with participants that they were nevertheless alert to the twin risks posed by the rapid economic change and mobility brought on by the oil boom in the countries of the Commonwealth of Independent States. The overall failure to see HIV/AIDS as an emerging priority, coupled with still evolving market mechanisms and a labour force that was still in the process of organizing were cited as the main challenges to mounting an effective business response in this region.

27. From the discussions it was clear that strong government leadership was very often the catalyst for private sector involvement, since the business sector often saw engagement on HIV/AIDS as part of its overall relationship with government, the workforce and society at large. Such engagement could be enhanced through:

(a) Open channels of communication with government and other stakeholders, leading to participatory decision-making and joint implementation of the resulting policies. The ILO code on HIV/AIDS and the World of Work provides a useful framework in this regard;

(b) Governments creating an enabling environment for private sector participation through regulation, the enactment of financial incentives and the provision of technical support;

(c) Emphasizing actions that companies can take, in addition to provision of antiretroviral drugs to the workforce, as available entry points for the business sector into the national response to HIV/AIDS. Provision of antiretroviral drugs represents the gold standard for business responses to HIV/AIDS, but there are many ways in which companies can ensure the well-being of their workforce and the survival of their businesses.

VI. Uniformed services

28. Participants from the uniformed services were present at both the Yerevan and Havana meetings and it was apparent from their participation that they appreciated the importance of HIV education and prevention programmes in the military. They were keenly aware that military service constituted a heightened risk for young men, inculcating them with attitudes of aggression and risk taking, and removing them, often for the first time, from the constraints of family and community. That risk was

said to increase even further with deployment into conflict zones on military or peacekeeping operations.

29. At the same time, it was emphasized that the discipline of military life offered unusually good opportunities for education and prevention training, and that with effective training, members of the uniformed services could be transformed into effective peer advocates for prevention in wider society.

30. In citing the experience within the Commonwealth of Independent States, participants noted that senior commanders were initially slow to recognize the scope of the disease and the dangers to readiness that it posed. Training in HIV/AIDS prevention and treatment is now compulsory at all levels of the military. Testing of recruits is, however, usually mandatory and in a recent call up of 2 million conscripts aged 18 years in one country, some 5,000 recruits tested positive for HIV. This was far higher than expected and supported the call for expanded education and prevention efforts among young people in general.

31. Despite progress, there was a need to strengthen existing programmes. Some military chaplains opposed condom use, thereby weakening prevention efforts. HIV-positive personnel were often dismissed, raising human rights concerns and discouraging soldiers from presenting for voluntary counselling and testing. The lack of access to antiretroviral treatment acts as a further disincentive.

32. At the Havana meeting, representatives of the uniformed services of Brazil and Cuba noted that aspects of local culture allowed for very direct and effective prevention messages. They attributed the success of their programmes to the following factors, which could serve as useful advice for others:

(a) Strong education and prevention training programmes at every level, and closely integrated with civilian health and prevention programmes;

(b) Accountability in the ranks, with officers taking responsibility for the health and welfare of their troops;

(c) Strict confidentiality and protection from stigmatization. HIV-positive soldiers remained in service and faced discharge solely on medical grounds;

(d) Access to care and treatment in the military and in civilian life.

33. Other suggestions to enhance the effectiveness of the response among uniformed services included:

(a) An emphasis on young recruits through the training of peer educators;

(b) Reinforcement of HIV/AIDS awareness and prevention training for future peacekeepers and demobilizing personnel, prior to their leaving the base.

VII. Conclusions

34. The acute and continuing shortage of resources — financial, technical and human — represents the single greatest obstacle to the achievement of the targets set at the twenty-sixth special session of the General Assembly in all three regions.

35. Even the effective deployment of available resources depends on better cooperation between Governments and civil society, which in turn requires:

(a) Stronger protection against stigmatization;

(b) Greater respect for human rights, especially those of people living with HIV/AIDS;

(c) The expansion of space for dialogue, in order to build trust, identify obstacles and strengthen partnerships;

(d) A clear division of responsibility, accountability and authority between the stakeholders, recognizing the different roles and contributions of each.

36. There is an urgent need to scale up action on all fronts in the battle against HIV/AIDS in order to reach the targets contained in the Declaration of Commitment. Special efforts are needed to expand the access to treatment and care in developing countries if the grip of HIV/AIDS on those infected and affected is finally to be broken.

37. National and regional efforts to address HIV/AIDS are in need of intensified international support. While resources to fight HIV/AIDS are increasing, they remain far below the levels required.